

## Health sector informal payments in Russia

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The Russian Constitution declares the right of citizens to free medical care delivered by public medical facilities. This guarantee *does not include some services such as dentures, plastic surgery, etc.* Currently, medical services delivered by private facilities and practitioners are *paid for only by individuals, not public financing programs.* According to existing laws, *disabled persons, some chronic invalids, and veterans of war have the right to free or partially reimbursed drugs.* For most Russians, drugs for outpatient treatment are *not provided free and must be purchased in pharmacies.* In addition to these "formal" costs incurred by individuals, *an additional amount has been collected from Russian citizens through informal payments to health providers.*

The informal payments to health providers have been reported in the Soviet Union at earlier times. According to results of a public survey conducted in May 1990, 35% of the interviewees had had some experience with respect to unofficial purchase of pharmaceutical drugs, and 19% of all respondents had been obtaining dental care from privately practicing dentists. Meanwhile the requirement for such payments has increased in Russia in recent years.

Since 1992, Russia has undergone dramatic economic changes. While markets have opened, economic statistics show a continuing fall in economic activity. With the Russian economy contracting, and continuing problems in tax collection and budgets, public funds available for health care have been severely restricted. During the 1991-1997 period, GDP decreased in the comparable assessment by 38%. The public financing of health care was reduced by 21% in the comparable assessment. In 1997, spending for health care by all levels of Government and mandatory health insurance ("MHI") funds was reported to be 3.5 per cent of the GDP or approximately 634,000 *old* rubles (\$109) per capita. *Funds from government and MHI funds are insufficient to cover the necessary expenses of existing state and municipal medical facilities and to provide medical services guaranteed to the citizens. Rather than reducing the size of the network, government spread available public funds thinly over the existing network of medical facilities.* Other expenses are financed partly or are not financed at all. Many national specialty institutions have suffered severe budget cuts which force them to ration "free" procedures and make the facilities dependent on private fees to perform much specialty care. A tendency to spontaneous and unofficial replacement of free services with paid ones is today increasing.

### ***Household expenditures on medical care***

Only a limited amount of research is available to quantify the level of Russian household expenditures on medical care. From 1992 to 1996, the nationwide longitudinal household survey sponsored by USAID (the Russia Longitudinal Monitoring Survey, RLMS) did collect data on two expense elements; drugs, and other medical care. The survey shows that out-of-pocket payment for drugs and medical care increased from 0.9% of household expenditure in September 1992, to 3.5% in October 1995 and October 1996. But the survey was not specifically designed to monitor formal and informal payments. *There are reasons to consider the collected data an underestimate of the real payments. Because of high tax rates and traditional suspicions, data reported by respondents on total expenditure may be understated to hide some household income.* According to the survey conducted in October 1996, the expenditures on medical care were about 3.3 thousand rubles per capita. That is *slightly less than the official Russian data* on the average monthly expenditures on medical care in 1997 which equalled 3.6 thousand rubles per capita.

In January 1998, the Institute of Social Research (ISR), a Russian survey research organization, conducted a 3,000 household survey of medical expenditures. The survey was performed under a contract with Boston University School of Public Health and funded from Boston University's Cooperative Agreement with USAID. The sample was designed to capture a statistically representative picture of households living throughout the country, including those in the more prosperous urban areas of St. Petersburg and Moscow. Surveys were conducted in each of eleven regions of Russia, with representative areas within each region selected for sampling. Interviews were conducted in 13 large cities, 29 medium sized and small cities and 38 rural areas. Respondents were chosen at random from voter registration lists within the selected interviewing areas.

Table 1. Average household expenditure on health care services

Type of service	Rubles (,000)	Percent of total spent on health services
Prescription drugs in pharmacies	52,7	22.7
Non-prescription drugs	71,7	30.9
Dental care	39,2	16.9
Inpatient care	43,9	18.9
Outpatient medical care in facilities	21,2	9.1
Private practice	3,4	1.5
Total	232,1	100

Respondents were asked detailed questions about household expenditures for drugs and medical care in the month of December, 1997. 2,238 households (75%) reported such payments. Table 1 shows the average household health care expenditures reported by the respondents.

The average household spent 232,000 rubles (\$39) on health care in December 1997. 46 percent of this amount was spent on medical *and dental care? The rest on drugs.*

Respondents were explicitly asked to differentiate, for each type of service, between payments made formally at the cash desk and those made directly to employees or professionals "under the table." According to the household survey, the under the table payments *are substantial*, and most of them are *collected in* public health institutions (Table 2). In December 1997, 23.8% of the households made official payments to public and agency-controlled facilities, while 7.4% of the households reported of unofficial payments (by-passing the cash-register); 3% of the interviewees made additional payments to physicians in these facilities officially and 12.6% made unofficial payments.

Table 2. Percentage of households which made official payments for their members' treatment and under the table payments to physicians, nurses, etc. in 1997

Health providers	Official payments (via cash-register)	Under the table payments (by-passing cash-register)
Public or agency-controlled polyclinic or hospital		
General payment for care Plus:	23.8	7.4
Separate payments to physicians	3.0	12.6
Separate payments to nurses, etc.	0.6	5.9
Private polyclinic or hospital		
General payment for care Plus:	10.7	1.6
Separate payments to physicians	2.3	3.3
Separate payments to nurses, etc.	0.4	0.7

It should be noted that the payments made formally at the cash desk to public facilities are mostly payments for medical services that, *according the existing laws*, should be free for citizens. Because of the shortage of public funds the facilities suggest *that* patients contribute *to the cost of* treatment via *the* cash register. These payments *for medical care and for drugs for treatment in inpatient and outpatient clinics* are illegal from the point of view of the Constitution, but they are considered by the patients as official payments to the facilities and their staff. Such transfers *might* be called as quasi-formal payments.

### ***Official and under the table payments by type of services***

In all, 15.4% of household payments for drugs and medical services were "under the table." Most of this money was spent for drugs and medical materials and devices and a *smaller portion* went to individual physicians and laboratory staff. Tables 3 and 4 show the percentage of household expenditures for each type of service which went "under the table," and the proportion of the total of such unofficial payments for each health service and provider type. The greatest burden of "under the table" payments is for inpatient care in public hospitals. Over a third of all payments made for inpatient care, which total 2.6% of household income, are made unofficially. These payments for hospital services are 35.6% of the total of all unofficial transfers. The main recipients of these payments are managers of facilities and physicians; 11.5% of all payments associated with admission to a public hospitals are made as a lump sum by passing the cash register; plus 12.3% are additional under the table payments to physicians; 3.0% are unofficial transfers to the nurses.

Table 3. Percentage of category paid under the table in December 1997.

Type of Service	Percentage of category paid under the table	Percentage of all under the table payments
Drugs in pharmacies	5,1	18,0
Dental care	23,2	25,5
Inpatient care in public facilities	34,4	35,6
Inpatient care in private facilities	4,5	0,9
Outpatient medical care in public facilities	29,0	13,0
Outpatient medical care in private facilities	18,3	2,7
Private practice	29,0	4,4
Total	15,4	100

One surprise of the survey was the discovery that "under the table" payments are substantial in explicitly private facilities that officially provide medical services on a paid basis. Because the number of private clinics, hospitals and physician offices is so limited, the total of "under the table" payments in such facilities is only 8.1% of all unofficial payments.

However, almost one dollar in every five paid for care in private outpatient clinics and one dollar in every three paid to private practitioners are paid "under the table." The shadow payments to physicians and to nurses in private inpatient clinics are 1.7% and 2.8% of total expenditures on admission to these clinics *respectively*.

Why should a private practitioner collect funds in the same way as an underpaid physician in a public facility? Perhaps the ethic of "under the table" payment is so ingrained that it does not die when fees can be freely charged. Or, perhaps private practitioners continue to collect fees in this

way to avoid tax liabilities. *Taxes are perceived as exceedingly heavy by private practitioners.*

Table 4. Percentage of category paid in December 1997.

Expenditure items and health care facilities where the payments were made	Percentage of category paid officially (via cash-register)	Percentage of category paid under the table (by-passing the cash-register)
Prescription drugs purchased at pharmacies	95.6	4.1
OTC drugs purchased at pharmacies or other settings	94.1	5.9
Payments for dental care provided by:		
public polyclinic or hospital	86.2	13.8
private polyclinic or hospital	84.5	15.5
officially practicing physician	60.9	39.1
unofficially practicing physician	30.5	69.5
Payments associated with admission to a public or agency-controlled hospital:		
General payments for treatment	73.6	26.4
Plus additional payments:		
for drugs and materials	80.0	20.0
laundry and bed-clothes	26.2	73.8
to physicians	3.9	96.1
to nurses and other hospital personnel	30.8	69.2
for laboratory tests	90.2	9.8
Payments associated with admission to a private hospital:		
General payments for treatment	100	0
Plus additional payments:	100	0
for drugs and materials	100	0
laundry and bed-clothes	100	0
to physicians	86.8	13.2
to nurses and other hospital personnel	7.8	92.2
for laboratory tests	100	0

Expenditure items and health care facilities where the payments were made	Percentage of category paid officially (via cash-register)	Percentage of category paid under the table (by-passing the cash-register)
Payments for outpatient services provided by public outpatient facilities:		
General payments for treatment	52.3	43.7
Plus additional payments:		
for drugs and materials	89.2	10.8
to nurses and other hospital personnel	12.2	87.8
for laboratory tests	85.0	15.0
Payments for outpatient services provided by private outpatient facilities:		
General payments for treatment	80.7	19.3
Plus additional payments:		
for drugs and materials	94.1	5.9
to nurses and other hospital personnel	10.6	89.4
for laboratory tests	92.4	7.6
Payments to officially and unofficially practicing physicians:		
General payments for treatment	59.0	41.0
Plus additional payments:		
for drugs and materials	36.2	63.8
to nurses and other hospital personnel	27.6	72.4
for laboratory tests	63.9	36.1

Under the table payments are the smallest percentage of total household payments for drug costs---only 5%. Nonetheless, because of the high total cost of drugs, such payments amount to 18% of the total of unofficial payments. It seems likely that there are fewer demands for under the table payment when obtaining drugs because the market for pharmaceuticals is open, and patients have been expected to pay for many outpatient drugs since Soviet times.

### ***Social and residential differentiation of payments***

In the circumstances when formally free medical services *must* be paid by patients, the lower income groups and the households living out of big cities are in the worse position. Out of pocket health care expenditures are clearly regressive (Table 5). They pose a heavier burden on lower income groups.

Table 6 shows how reported costs were distributed according to the residence of the household. Looking at the geographic distribution of the sample results gives another insight into the nature of household expenditures on health care. This analysis confirms that out-of-pocket spending is not a function of higher disposable income and a greater

supply of services. Moscow, and to a lesser extent St. Petersburg, have prospered (at least relatively) in the years since the break up of the Soviet Union. The percentage of total national wealth in Moscow has grown, with proportionately higher incomes. Moscow has always been the "medical capital" of Russia, with a disproportionate share of specialty facilities. Yet the data show that residents of Moscow and St. Petersburg pay less for medical care, both absolutely and proportionately, than do other residents of Russia.

Table 5. Drug and health care expenses in the overall households' budgets by income quintile (in December 1997).

Income and health expenses	Income quintiles					Total
	One	Two	Three	Four	Five	<b>Average</b>
Average income per household, rub (,000)	410,6	819,9	1228,9	1818,8	4091,0	1687,8
Total drug and health care expenses /income	0,27	0,20	0,18	0,15	0,09	0,14
Official drug expenses/income	0,17	0,13	0,11	0,06	0,04	0,07
Unofficial drug expenses/income	0,00	0,00	0,01	0,00	0,00	0,00
Official hospitalization expenses/income	0,02	0,02	0,02	0,03	0,01	0,02
Unofficial hospitalization expenses/income	0,01	0,01	0,01	0,01	0,01	0,01
Official expenses for outpatient care/income	0,02	0,01	0,01	0,01	0,01	0,01
Unofficial expenses for outpatient care/income	0,00	0,00	0,00	0,00	0,00	0,00
Official expenses for dental care/income	0,02	0,02	0,03	0,02	0,01	0,02
Unofficial expenses for dental care/income	0,01	0,01	0,01	0,01	0,01	0,01

The differences in expenditures for other medical services are not as dramatic as those for drugs, but residents of small and medium sized cities still pay 20% more than those in Moscow and St. Petersburg, while rural residents report spending slightly more *than residents of the two largest cities* for other medical services. Rural Russians spent 8% of their income *on medical care* compared to the 5% of income reported by respondents in the two major urban centers. Why might this be the case, when smaller cities, and rural areas especially, will have a more limited range of health care services, and perhaps lower expectations for medical care? The one possible explanation is that these areas are under the

greatest economic stress, and thus are most likely to default on payrolls in health care facilities. Formally, or informally, the facilities and their staff then resort to user fees and "under the table" payments to supplement their meager income or replace lost wages. In effect, the cost of the limited services which are available in these regions is being transferred from the public to private spending as a result of economic hardship.

Table 6. Distribution of reported drugs and medical services expenditures by place of residence

Location of residence	Type of payments	Values for average household, rubles (,000)		
		Total	drugs	medical services
Moscow and St.Petersburg	Total	204,6	99,0	105,6
	via cash <i>register</i>	184,9	97,5	87,4
	by passing cash <i>register</i>	19,7	1,5	18,2
	% of incomes	10%	5%	5%
Oblast and regional centers	Total	225,2	124,1	101,1
	via cash <i>register</i>	195,4	119,3	76,1
	by passing cash <i>register</i>	29,8	4,8	25,0
	% of incomes	12%	7%	5%
Small and medium sized cities	Total	261,0	139,2	121,8
	via cash <i>register</i>	216,5	129,9	86,6
	by passing cash <i>register</i>	44,5	9,3	35,2
	% of incomes	15%	8%	7%
Rural	Total	227,4	119,1	108,3
	via cash <i>register</i>	186,1	110,3	75,8
	by passing cash <i>register</i>	41,3	8,8	32,5
	% of incomes	17%	9%	8%

The second possible explanation is that *many* kinds of *specialty* medical services are provided only in big cities. Those who live there constantly have more possibilities to receive such services free. *Patients who come from elsewhere in Russia to receive these specialty services must pay for their care, since free care is reserved for local residents. This hypothesis is supported by the data which show that residents of big cities incur half the burden of informal medical payments when compared to citizens of other areas.*

### ***Assessment of private health financing in Russia***

The study results give direct insights into the burden which an underfunded health care system poses on Russian families. However, the data must be further interpreted to compare aggregate levels of public and private spending. The survey captured a snapshot of expenditure in December, a month when illness and accident may be higher than normal due to winter weather, but when elective medical expenditures may be reduced by the year end holidays. Another important seasonality factor is the variation in monthly income through the year. According the official data, December 1997 income was 30% higher than the average for the entire year.

Because of these seasonality factors, we must make some adjustment to the observed expenditures to extrapolate to annual private expenditures which can then be compared with reported public expenditures for 1997. The survey showed an average per capita health expenditure of 83,500 rubles (\$14) in December. We have no data to adjust for seasonal medical demand. To adjust for fluctuations in monthly income, we make the conservative assumption that medical expenditure will vary *directly* with income, and therefore divide the December result by 1.3 to obtain the average monthly expenditure throughout 1997.

This assumption assumes that medical expenditure has an elasticity of one with respect to income. Historically, we know that countries, as they develop, show an elasticity of aggregate medical expenditure with respect to national income which is greater than one. However, our survey data showed that out of pocket expenditure does not increase as rapidly as income *in Russia today*, and we therefore conclude that this assumption is conservative. The result is to project an annual out of pocket health care expenditure of 770,800 rubles (\$129) per capita.

Table 7. Private payments for medical services and drugs in 1997,  
trillion rubles

	Type of expenditures	Survey estimate	Conservative estimate
1	Drugs purchased at pharmacies	60,8	39,1
2	Payments for medical care, total	52,7	30,5
	Officially (via cash-register)	38,4	22,2
	Under the table (by-passing the cash-register)	14,3	8,3
3	Total	113,5	69,6

Table 8. Private payments for medical services and drugs in 1997  
as a % of GDP

	Type of expenditures	Survey estimate	Conservative estimate
1	Drugs purchased at pharmacies	2,35	1,51
2	Payments for medical care, total	2,04	1,18
	Officially (via cash-register)	1,48	0,86
	Under the table (by-passing the cash-register)	0,55	0,32

3	Total	4,39	2,69
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If we cumulate this projection of household health service payments over the Russian population of 147.3 million people we obtain an estimate of 113.5 trillion rubles (\$19,6 billion) for private health expenditures in 1997. This aggregate can then be compared with official data on health expenditures by Governments and mandatory health insurance.

Table 9. Health care spending in 1997.

№		Amount, trillion rubles	As a percent of GDP
1	State budget	75.1	2.90
2	Payroll taxes on compulsory health insurance	18.3	0.71
3	Total public spending (1 + 2 )	93.4	3.61
4	Official private payments for medical services and drugs in medical facilities	22.2	0.86
5	Under the table private payments for medical services and drugs in medical facilities	8.3	0.32
6	Total private payments for medical services and drugs in medical facilities (4+5)	30.5	1.18
7	Private payments for pharmaceutical drugs purchased in retail pharmacies	39.1	1.51
8.	Expenses for voluntary health insurance	3.4	0.13
9	Total private payments (6 +7+8)	73.0	2.82
10	Total	166.4	6.43

Other sources which can be compared with estimates from this study show far lower values for private spending. If we use drug import and production data, adjusted for allowable retail markups, this would suggest total private drug expenditures of 17.4 trillion rubles compared to the projections from the survey estimate of 60.8 trillion rubles. Official estimates of private expenditures in other health service categories run less than 1/6 of the values we measured. Tables 7 and 8 present two estimates of total private spending, that derived directly from our survey results, and an amount (conservative estimate) half way between these earlier estimates and the values derived from the survey.

In Table 9 we compare official figures on health spending by government and mandatory health insurers with *the conservative estimate of private expenditures, private health care spending and voluntary health insurance premiums are 2,82% of GDP and 44% of total health care spending.* Taken at face value with *the same* extrapolation from monthly to annual values, the survey suggests that private health expenditure in Russia now

exceeds public expenditure. Direct extrapolation of our survey suggests that private expenditure is 56% of the total and 1.3 times public expenditure.

### ***Assessment of Russia's informal health care market***

*Using our conservative extrapolation of survey results, under-the-table payments of the Russian citizens total 10.2 trillion rubles (0.38 percent of the country's GDP, or 6.1 percent of the total amount of public and private health funding), including 8.2 trillion for health services, and 2.0 trillion for pharmaceuticals purchased outside health care facilities.*

*Our calculation shows that official payments to health facilities (via cash register) for health services and drugs amounted to 22.2 trillion rubles, or 0.86 percent of GDP. However, according to Goscomstat/Russia, total volume of health services officially paid for by Russian citizens in 1997 equalled 8.3 trillion rubles (0.31 percent of GDP). Thus, the actual amount of private payments for health care (not including drugs purchased officially in pharmacies) is 2.7 times higher than the officially reported.*

*The overall size of Russia's informal health care market may be estimated as a sum of two components: 1) total amount of under-the-table payments for health services and; 2) the difference between total amount paid by the population for health services via cash register, and Goscomstat's estimates of total private payments for health care. This gives us 22.2 trillion rubles or 0.86 percent of Russia's GDP. Continuing to use the more conservative estimate derived from total informal payments for medical services reported in our survey, we find that such informal payments aggregate to an amount equal to 24% of total reported public health expenditures.*

*Goscomstat's estimates include some items in addition to formal payments for medical services. So our calculation underestimates the quasi-formal payments, i.e. payments to the facilities via cash register for medical services that should be free according the Constitution.*

Table 10. Informal health care market in 1997

		Trillion rubles	% of GDP
1	Amount of under-the-table payments for health services in health care facilities	8.3	0.32
2	Citizens' payments to health care facilities exceeding those officially reported by Goscomstat	13.9	0.54
3	Informal market capacity (1 + 2)	22.2	0.86

### ***Policy recommendation***

With combined public and private health spending at least 6.4% of GDP, and perhaps as much as 8.1% of GDP, Russia approaches the lower levels of total health spending (as measured by percent of GDP) in OECD

countries. Thus, the declining results of the Russian health system in the 1990's (as measured by life expectancy) cannot be explained simply by a lack of aggregate health spending. To some extent, private payments have substituted for public funds and kept the total spent on health care at a level, measured as a percentage of the GDP, which produces better health results in other industrial countries with educated populations. The challenge for the Russian health care system is to use the total spent more effectively.

One way to make the system more efficient and equitable would be to explicitly limit the benefit package provided under the constitutional guarantee of free care. Public funds would be concentrated to assure that the basic benefit package is available to all citizens, either free, or with an affordable copayment. While the Ministry of Health has explored this option, there are no clear national guidelines which specify what medical procedures are not covered by the basic guarantee. De facto, many tertiary care procedures are now available to Russian citizens only if their oblast health committee or insurance company agrees to pay, and willingness to pay is very much a function of the funds available. Others must pay privately to the institution or go without the service. There is a fear that any clear national statement of "excluded" procedures would be contrary to the wording of the Constitution, and politically unacceptable despite the current reality.

Another alternative for rationalizing the funds which are available to government would be to more specifically authorize a schedule of copayments, with the funds collected used by the institution to augment public funding. Such a scheme might even be organized so that certain vulnerable groups defined by income or chronic disease would receive an exemption from copayments, or have annual out-of-pocket payments capped at an affordable level. Such an income related limitation copayments is attractive. However, the reluctance of Russians to accurately report income to any governmental agency makes such an exemption system difficult to operate. Nevertheless, it is clear that the Russian population is now making considerable de facto copayments to their public health institutions. From the point of view of the Russian citizen, the system would be improved if copayments were explicitly stated, retained by the institution to improve service, and if under the table payments were effectively banned.

A system of substantial copayments might be combined with a program of voluntary health insurance for coverage of such payments, as in France, or the U.S. Medicare program. While the evidence is that such universal insurance of copayments has been inflationary, the risk pooling which would result would be preferable to the current situation in Russia, where the household which needs medical care must fully cover the "de facto" costs from its own resources, or those of the extended family.

The survey reported here raises questions. It does not provide answers. However, health reforms in Russia which ignore the size of private payments will not succeed. For the foreseeable future, it is likely that private payments will continue near the levels we have measured. Policies must be designed to make private patients as efficient as possible, and

strive to remove the economic barriers to critical drugs and services which may be damaging the health of the average Russian.